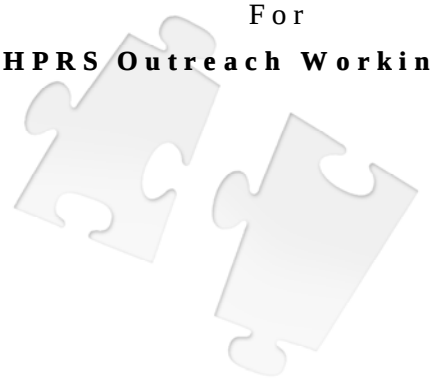
ONTARIO HEALTH PROMOTION RESOURCE SYSTEM
(OHPRS)

AWARENESS RAISING TO REACH ABORIGINAL POPULATIONS

by
TAP Resources and Associates

For
OHPRS Outreach Working Group



April 2007

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Acknowledgements

The Ontario Health Promotion Resource System (OHPRS) commissioned this report to assist them in understanding how they can or may extend their support system within and to the aboriginal population in Ontario. OHPRS in the commission of this report is responding to a need identified in their 2004 needs assessment, where a need for material to support health promotion work with aboriginal people was identified. In order to effectively respond to this niche market and unique cultural group OHPRS is taking the initial steps to first understand the complexities of the aboriginal population, their diverse cultures, and the current level of health promotion services available to aboriginal people. As part a part of this exercise OHPRS has asked for the development of a strategic plan to assist them in understanding how they can increase their capacity to serve the aboriginal population within their existing parameters.

Our team of writers would like to express their appreciation to OHPRS for the opportunity to work with them to identify potential opportunities in supporting aboriginal people's health promotion in Ontario.

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Awareness Raising to Reach Aboriginal Populations

Aboriginal Peoples of Ontario Health Overview

1. Aboriginal People

The Canadian Constitution recognizes three groups of Aboriginal peoples - the Inuit, Métis and Indian peoples. The Indian peoples now refer to themselves as First Nations.

First Nations

There are some 60 distinct First Nations who own 633 reserve territories across Canada and comprise a total population of approximately one million.[1]

There are 133 First Nations Communities in Ontario comprising a population of 131,560 people[2] The total population for Ontario is 11,285,545.[3]

These communities originated and belong to 14 district nations, each with their own language, customs and territories. These nations include the Algonquin, Mississauga, Ojibway, Mohawk, Onoyota=a:ka (Oneida), Tuscarora, Cree, Cayuga, Seneca, Onondaga, Chippewa, Odawa, Pottawatomi and Delaware. Although the focus of political activity is centred within the provincial boundaries, the traditional territories of the nations extend beyond provincial and Canada/US borders.

Ontario First Nations are represented by the Provincial organization, the Chiefs of Ontario, which is made up of several regional Chiefs' 'organizations such as Nishhawbe Aski, Grand Council Treaty Number Three, Anishinabek, Association of Iroquois and Allied Indians and the Independent First Nations of Ontario.

Inuit

To provide a context for Ontario the total Inuit population in Canada is 45,000.

There are 1,375 Inuit residing in Ontario.[4] The Inuit have a small presence primarily in Ottawa and are represented nationally by the Inuit Tapiriit Kanatami.

There is no provincial Inuit organization. While the Inuit are one of the three constitutionally recognized aboriginal peoples their small population size in Ontario does not provide sufficient information to be included in this summary.

Métis

Recently the Powley Supreme Court decision addressed and affirmed section 35 Constitutional rights of the Métis people to hunt for food. The decision provides some guidance on who can claim be Metis. It refers to distinctive peoples of mixed ancestry who developed their own customs, practices, traditions and recognizable group identities separate from their Indian, Inuit and European ancestors. The term "Métis" does not refer to all individuals of mixed Aboriginal and European ancestry.

[1] 2001 Canadian Census data

[2] 2001 Canadian Census data

[3] 2001 Canadian Census data – see attached chart

[4] 2001 Canadian Census data

The criteria for an individual to prove they are a member of a Métis community and are able to exercise that community's Aboriginal right are: an individual must first demonstrate membership in a present-day Métis community that can trace its existence back to an historic Métis community, with a distinctive culture and to prove membership, an individual must self-identify as Métis, have an ancestral connection to an historic Métis community, and be accepted as a member by this community.

In Ontario there are two definitions of who is a Métis. One definition requires a connection to the original Red River settlement and the other is based on simple mixed ancestry. The definition of who is a Métis, or who is allowed to join a Métis organization is broadly based. Most Métis organizations define a Métis as someone of mixed white and Indian ancestry (or of mixed non-Indian and Indian ancestry); and historically non-status Indians were welcomed to join. No distinction was made between Métis with roots in Red River, Manitoba and those Métis whose ancestry was founded in other parts of Canada; no cultural affiliation or references to historical populations or events were needed for a person to join the political organizations. There was nothing to prevent a non-status Indian from identifying as Métis if he/she wished. [5]

The 2001 Canadian census estimates there are 48,340 Métis residing in Ontario[6]
One in three (31%) of the total Aboriginal population in the province is Métis. Census data for 2001 indicates that Métis share similar socio-economic and health profile as other Aboriginal Peoples.

Métis in Ontario are represented by several organizations including the Ontario Métis Aboriginal Association (OMAA), the Métis Nation of Ontario. There are other Ontario Métis organizations, such as Red Sky and smaller local affiliates.

2. Aboriginal Population

First Nations [7]

First Nations live in 133 aboriginal communities throughout all of Ontario. First Nations are the only Aboriginal people located on Indian Reserves within First Nation Territories.

Inuit

Inuit are primarily located in northern Canada, north of the 60th parallel. In Ontario they are concentrated primarily in the Ottawa area.[8] which enables them to access health and social services.

Métis

The Métis Nation of Ontario is divided into 9 regions. There are also various community councils throughout the province. The majority of Métis are living in the provinces of Alberta, Manitoba and Ontario and 68% of Métis live on the prairies (Alberta, Saskatchewan and Manitoba). The highest urban populations are:

- Winnipeg (31,395)
- Edmonton (21,065)
- Vancouver (12,505)
- Calgary (10,575)
- Saskatoon (8,305)

[5] From Ecclectica: The Métis Indians of Ontario by Joe Sawchuk

[6] 2001 Canadian Census data

[7] See attached map of Ontario First Nations

[8] 2001 Canadian Census data

It should be noted that it has been estimated that from 40% to 60% of the Aboriginal population reside in urban centres in Ontario primarily in the largest cities. Among First Nations this population is in flux with citizens moving on and off reserve on a seasonal basis for work and education purposes.

Urban aboriginal peoples are largely serviced by the National Association of Friendship Centres. NAFC is a national, non-profit Aboriginal organization that represents the views and concerns of 117 Friendship Centres and 7 Provincial/Territorial Associations (PTAs) across Canada.

Friendship Centres offer a variety of programs and services in a culturally appropriate manner, practicing an open-door policy where anyone, regardless of race, religion, income or nationality can access programs. Visitors to Friendship Centres can often find access to cultural programs, education and training, employment counseling, health programs, children and youth programs, recreation programs and economic development.

Friendship Centres also offer language training, entrepreneurial training, skills development, computer training, work site placements, nutrition programs, healing circles, alcohol and drug counseling, summer camps, day care centres, youth peer counseling, youth drop in centres, organized sports and leagues, wilderness training and facility rentals. Many Centres also have arts and crafts shops and organize Aboriginal Pow Wows and other events throughout the year.

Roughly 500,000 people across Canada access programs and services offered by the 117 Friendship Centres every year.

3. Aboriginal Health Status

RCAP (Aboriginal Peoples in General)

In 1996 the *Royal Commission on Aboriginal Peoples (RCAP*) issued its five volume final report which included some 400+ recommendations. The *Royal Commission on Aboriginal Peoples* represents the most comprehensive study of Aboriginal issues ever undertaken in Canada. After five years of study and consultations with Aboriginal peoples, it released its recommendations including ideas on improving the health of Aboriginal peoples.

The mandate of the Commission directed its attention to social issues of concern to Aboriginal peoples:

"The Commission may study and make concrete recommendations to improve the quality of life for Aboriginal peoples living on-reserve, in native settlements and communities, and in rural areas and cities. Issues of concern include, but are not limited to: poverty, unemployment and underemployment, access to health care and health concerns generally, alcohol and substance abuse, sub-standard housing, high suicide rates, child care, child welfare and family violence."

RCAP observed that within Canada's borders, there are two realities. It stated most Canadians enjoy adequate food and shelter, clean water, public safety, protection from abject poverty, access to responsive medical and social services, and the good health that results from these things. However, Aboriginal peoples are more likely to face inadequate nutrition, substandard housing and sanitation, unemployment and poverty, discrimination and racism, violence, inappropriate or absent services, and subsequent high rates of physical, social and emotional illness, injury, disability and premature death.

RCAP stated the gap separating Aboriginal from non-Aboriginal peoples in terms of quality of life, as defined by the World Health Organization, remains stubbornly wide:

Life expectancy at birth is about seven to eight years less for registered Indians (First Nations) than for Canadians generally

Part of this difference in life expectancy is explained by high rates of infant mortality among registered Indians. For infants, the death rate is about twice as high as the national average. There are also high rates of injury and accidental death among Aboriginal children and adolescents. Mortality in all age groups is higher for registered Indians than for Canadians generally.

Infectious diseases of all kinds are more common among Aboriginal peoples than others.

The incidence of life-threatening degenerative conditions such as cancer, heart, liver and lung disease — previously uncommon in the Aboriginal population — is rising.

Overall rates of injury, violence and self-destructive behaviour are disturbingly high.

Rates of overcrowding, educational failure, unemployment, welfare dependency, conflict with the law and incarceration all point to major imbalances in the social conditions that shape the well-being of Aboriginal people.

First Nations - Regional Health Survey (RHS) 2002

The RHS was conducted in 238 First Nations Reserve and other First Nation communities between August 2002 and November 2003, with more than 22,000 participants across the country. The RHS included three questionnaires designed for adults (18 years and over), youth (12 to 17 years), and children (0 to 11 years).

The RHS was coordinated by the First Nations Centre at the National Aboriginal Health Organization (NAHO) and ten First Nations regional organizations. Nationally, the First Nations Information Governance Committee (a standing committee of the Assembly of First Nations Chiefs Committee on Health) oversees and guides the survey.

This snapshot, provided by the Regional Health Survey, of the living conditions and health of First Nations living in their communities identifies significant gaps and areas of concern:

- First Nations have lower levels of education than Canadians in general.
- First Nations were 25 times more likely to be living in crowded homes in 2002 than Canadians were in 1991.
- A considerably larger proportion of First Nations homes are in need of major repairs compared to the homes of Canadians overall.
- Mold and mildew affect a large number of First Nations homes.
- Water is considered unsafe in many First Nations homes.
- Basic services, such as running water, are not available in a substantial number of First Nations homes.
- There is a “digital divide” — proportionately fewer First Nations than Canadian homes have telephones, computers and Internet service.
- Smoking rates are more than double the Canadian average, but appear to be on the decline.
- Obesity rates in First Nations are twice as high as for Canadians.

- First Nations diabetes rates are 3 times the Canadian average among those 55 years and older and 6 times higher among those 35 to 54 years of age.

- Residential schools have had negative impacts on First Nations health and wellbeing.

- Many older First Nations adults do not receive needed home care services.

Métis Population Health Data and Information[9]

For almost every health status indicator or measurement, the health of Métis (along with First Nations and Inuit) is poorer than that of the overall Canadian population.

- 57.7% of Métis aged 15 and over reported excellent or very good health, with 25.4% responding good and 16.7 fair or poor. Of those aged 55 and over, 40.7% rated their health status as fair or poor.

- Most commonly reported chronic condition for Métis was arthritis or rheumatism at 19.5%. High blood pressure, asthma and stomach problems or intestinal ulcers were 12.7%, 11.7% and 10.5% respectively.

- 44.9% of respondents stated that keeping, learning or relearning an Aboriginal language was very or somewhat important whereas 51.2% said it was not very or not important.

- Of the 235,290 respondents, 5% attended a residential school while 95% responded that they did not.

- In 2001, 78.1% of Métis respondents completed post-secondary schooling. Of the Métis males surveyed, 20.9% did not complete post-secondary schooling and of this total, 27.2% stated financial reasons for not completing post-secondary schooling. Of the female Métis surveyed, 22.6% did not complete post-secondary schooling with 26.6% citing family responsibilities.

- Approximately 73% of Métis respondents completed elementary or high school as of the 2001 Census with 27% not completing either elementary or high school. For Métis males, 28.6% did not complete elementary or high school. Of the total males, 29.8% cited Wanted to Work as the primary reason for incomplete education. For Métis females, 25.6% did not complete elementary or high school, with 22.8% citing Pregnancy/Taking Care of Children as the primary reason.

Inuit

Insufficient information is available. Due to the small population of Inuit in Ontario the author was unable to find any statistics on the health of Inuit in the province.

4. Aboriginal Health Rights and History

Prior to European contact, Aboriginal peoples had well-developed concepts of health and medicine. Traditional Aboriginal medicine differed considerably among the Inuit, Métis and First Nations. However, Aboriginal health shared some consistent principles and values, such as the importance of spiritual well-being and balance in everyday life. In this sense, Aboriginal medicine was a way of life.

[9] *2001 Aboriginal Peoples Survey (APS II)*

RCAP wrote there is considerable evidence to show Aboriginal peoples enjoyed good health at the time of first contact with Europeans. Historical records and the findings of modern paleo-biology suggest that many of the illnesses common today were once rare, and that mental and physical vigour once prevailed among Aboriginal peoples.

RCAP stated the transformation of Aboriginal peoples from the state of good health that had impressed travelers from Europe to one of ill health, for which Aboriginal people were (and still are) often held responsible, grew worse as sources of food and clothing from the land declined and traditional economies collapsed. It grew worse still as once-mobile peoples were confined to small plots of land (Indian reserves) where resources and opportunities for natural sanitation were limited. It worsened yet again as long-standing norms, values, social systems and spiritual practices were undermined or outlawed.

Good health meant a balance of physical, mental, emotional and spiritual elements. If one of these elements was neglected, individuals became unbalanced and health suffered in all areas. For example, a troubled mind or spirit can cause sickness in the body, just as a poorly nourished body may weaken a person's mental function. While Aboriginal healers used a wide variety of medicines gathered from Mother Earth, medicine was not only used to treat the symptoms of illness, but worked holistically to seek the cause of the illness.

First Nations

In addition to an Aboriginal right to health governance many First Nations have a treaty right to health care. Treaties were entered into with settler governments on a government to government and nation to nation basis to protect Aboriginal communities, cultures and nations. The Iroquois described it with their treaty wampum belt called the Kaswentha or Two Row. Two parallel lines were drawn on a wampum belt made of shells to signify the equal relationship between the First Nations and the settler governments. In the same way the two line do not intersect, the two societies and governments were not to interfere with each other.

Across Canada many different First Nations exist, each with their own spirituality, territory, language and culture. Despite these differences, however, we share many similarities, particularly in terms of how we view our original relationships with Canada. For example, when European settlers first arrived on our lands, we acted accordance with our original instructions and attempted to live in friendship and peaceful coexistence. We acknowledged each other as sovereign nations and many of us entered into agreements or treaties with the European governments in order to protect our way of life and to establish and define our relationships more clearly.

It is important to remember, however, that none of our treaties stated that we were relinquishing, diminishing or extinguishing our inherent rights to govern ourselves. For many years now there has been a great deal of discussion regarding the existence of our inherent right to self-government as well as various processes for its implementation in First Nations communities.

Historically all First Nations were self sustaining healthy communities with their own practitioners, healers and medicines. First Nations believe that their right to health care is based on an inherent legal responsibility of the federal government to provide health services in lieu of land and resources surrendered throughout the country. Indeed, historical evidence indicates that the future well-being of First Nations was a major concern of Aboriginal peoples during the negotiations of treaties. Testimony from Aboriginal elders indicates that the Queen of England promised her subjects that she would look after them "as long as the sun shines." A specific reference to a treaty right to health is contained in Treaty 6, in which the Queen's representatives promised that a 'medicine chest' would be made available for access to Aboriginal peoples. Promises were also made during negotiations of several other treaties.

The Canadian Constitution recognizes the existing Aboriginal and treaty rights of the Aboriginal peoples of Canada. Aboriginal rights are based in indigenous knowledge, heritage, cultures and traditions encompassing all aspects of Aboriginal societies, including health jurisdiction.

One of these rights is the right to provide for the determinants of health, including control of health practices and the use of medicines for healing. These customs reflect the distinctive cultures of First Nations and the rights associated with these customs and traditions are unique to each First Nation.

There are both pre-confederation and post-confederation treaties in Ontario. Many of the earliest documented treaties were treaties of peace and friendship based on the principles of trust, respect and sharing. Although the written version of the treaties often did not convey the true spirit and intent of our peoples, it is with these principles that our forefathers entered into all of the treaties that exist today.

International Obligations of Canada

First Nations maintain that Canada must meet its international commitments to Human Rights. As a signatory of the United Nation's International Covenant on Economic, Social and Cultural Rights, Canada recognizes "the right to an adequate standard of living...including adequate food, clothing and housing; and the right to the continuous improvement of living conditions" (Article 11). Canada's commitment to the ICESCR is a legal obligation, therefore, failure to create the conditions for an adequate standard of living for Aboriginal peoples is a breach of international law.

The *Draft Declaration on the Rights of Indigenous Peoples (*Article 21) recognizes the right of indigenous peoples "to the improvement of their economic and social conditions, including...the areas of education, employment, vocational training and retraining, housing, sanitation, health and social security." It also provides: that "states shall take effective measures and special measures to ensure continuing improvements of their economic and social conditions."

Métis

According to the 2001 Census Canada data, one in three, or 31% of the total Aboriginal population reported being Métis. The Métis web-site states the history of the Métis people is the story of a people that are central to the formation of Canada. Born initially from unions between First Nations and Europeans, within a few short generations our populations had grown so expansively that we began to live apart from our First Nations relatives and form our own communities. Métis women and men

married each other giving birth to successive generations of Métis children. We developed our own language (Michif), our own culture and our own way of life.

The first provincial Métis organization formed in 1932 to call attention to the poverty Métis people were living in, and it was the first time in our recorded history that a specific call was made for attention to be paid to our health care needs.

The Métis Nation of Ontario (MNO) brings Métis people together to celebrate and share their rich culture and heritage and to forward the aspirations of the Métis people in Ontario as a collective. Initially formed in 1994, by Métis people from across the Province of Ontario the MNO now focuses on nation building. This dynamic is what has allowed the MNO to realize its monumental successes in such a short period of time and is what has brought our people together to claim our inheritance within the province of Ontario.

Its website states the MNO provides the opportunity through its activities to allow Métis communities across Ontario to flourish and to bring change to their socio-economic circumstances including improving their job and income status, finding funds for education, improving access to health care and creating self-sustainability.

Inuit

Insufficient information is available.

Aboriginal Health Priorities

The *Royal Commission on Aboriginal Peoples* (RCAP) represents the most comprehensive study of Aboriginal issues ever undertaken in Canada. After five years it released its recommendations in 1996 including recommendations on improving the Health of Aboriginal peoples.

RCAP recognized the need for a new Aboriginal Health and Healing Strategy. It said its analysis showed that the factors contributing to ill health of Aboriginal peoples stemmed not from bio-medical factors, but from social, economic and political factors. Given the many causes of Aboriginal ill health, Commissioners were convinced that the problem-by-problem approach of Canada's health care system is not adequate because it does not address underlying causes and cannot trigger the fundamental improvements in life circumstances that Aboriginal peoples need. Nor can very much difference be made simply by providing 'more of the same' — more money, more services, more programs, RCAP stated. Commissioners noted, such responses would indeed help some individuals in poor health, but this will not stem the flow of ill and dysfunctional Aboriginal peoples to fill up the spaces left by the newly cured.

RCAP stated although it was greatly disturbed by the evidence of continuing ill health in Aboriginal communities, it was also encouraged by the energy and imagination with which many Aboriginal peoples are tackling their health and social problems - they know what ails them. RCAP acknowledged, in testimony and consultation, Aboriginal peoples offered a critique of existing health and social services and proposed alternative ways of making progress toward health and well-being. They are already acting on those ideas in some communities.

RCAP Commissioners were struck by the fact that many of the insights of traditional values and practices echo those at the leading edge of

new scientific ideas on the determinants of health and well-being. We believe, they said, that there is, at the meeting point of these two great traditions — the Aboriginal and the bio-medical — real hope for enhanced health among Aboriginal peoples and, indeed, enhanced health for the human race. For Aboriginal peoples, the conviction that they have a contribution to make is deeply held and a source of strength.

1. Key RCAP Health Recommendations[10]

- Aboriginal, federal, provincial and territorial governments must acknowledge the determinants of health found in Aboriginal traditions and health sciences and endorse the fundamental importance of holism, - attention to whole persons in their total environment; equity, - equitable access to the means of achieving health and equality of outcomes in health status; control by Aboriginal peoples of the lifestyle choices, institutional services and environmental conditions that support health; and diversity, - an accommodation of the cultures and histories of First Nations, Inuit and Métis people that make them distinctive within Canadian society and that distinguish them from one another.

- Governments must recognize that the health of a people is a matter of vital concern to its life, welfare, identity and culture and is therefore a core area for the exercise of self-government by Aboriginal nations. Governments act promptly to conclude agreements recognizing their respective jurisdictions in areas touching directly on Aboriginal health; agree on appropriate arrangements for funding health services under Aboriginal jurisdiction; and establish a framework, until institutions of Aboriginal self-government exist

- Aboriginal organizations, regional planning and administrative bodies and community governments currently administering health and social services transform current programs and services into more holistic delivery systems that integrate or co-ordinate separate services. Aboriginal, federal, provincial and territorial governments incorporate in funding agreements plans for capital development and operating costs of a network of healing lodges

- Federal, provincial and territorial governments, and Aboriginal governments and organizations, must support the assumption of responsibility for planning health and social services by regional Aboriginal agencies and councils where these now operate, and the formation of regional Aboriginal planning

- Federal, provincial and territorial governments should commit themselves to providing the necessary funding, consistent with their jurisdictional responsibilities, to implement a co-ordinated and comprehensive human resources development strategy; to train 10,000 Aboriginal professionals over a 10-year period in health and social services

- Post-secondary educational institutions involved in the training of health and social services professionals, and professional associations involved in regulating and licensing these professions, should collaborate with Aboriginal organizations

[10] RCAP recommendations apply generally to all aboriginal peoples including Inuit, Metis and Indians (First Nations)

and governments to develop a more effective approach to training and licensing that recognizes the importance and legitimacy of Aboriginal knowledge and

- Governments, health authorities and traditional practitioners should co-operate to protect and extend the practices of traditional healing and explore their application to contemporary Aboriginal health and healing problems.

- Aboriginal traditional healers and bio-medical practitioners should strive actively to enhance mutual respect through dialogue and that they explore areas of possible sharing and collaboration.

- Non-Aboriginal educational institutions and professional associations involved in the health and social services fields must sensitize practitioners to the existence of traditional medicine and healing practices, the possibilities for co-operation and collaboration, and the importance of recognizing, affirming and respecting traditional practices and practitioners.

- Non-Aboriginal service agencies and institutions involved in the delivery of health or social services to Aboriginal peoples, and professional associations, unions, and other organizations in a position to influence the delivery of health or social services to Aboriginal peoples undertake a systematic examination to determine how they can encourage and support the development of Aboriginal health and social service systems, and improve the appropriateness and effectiveness of mainstream services to Aboriginal peoples; engage representatives of Aboriginal communities and organizations in conducting such an examination.

2. First Nations – Regional Health Survey (RHS)[11]

The First Nations Regional Longitudinal Health Survey (RHS) is the only national research initiative under complete First Nations control in Canada. It is a partial fulfillment of one of the RCAP recommendations for First Nations control over their health governance. It is data collection and analysis by First Nations, of First Nations data. The first cycle started in 1997 and will end in 2014. It contains the evidence needed for First Nations to make "evidence based decisions." and can be used as a catalyst for change and to improve the lives of First Nations. It is a new "Red Standard" for First Nations community based research. RHS was formalized in July 1996 with NAHO, AFN and Health Canada.

In 1998 RHS managers developed OCAP Principles (Ownership, Control, Access and Possession). OCAP meant that First Nations controlled data collection processes in their communities. First Nations now own, protect and control how information is used. Access to First Nations data is important and First Nations now determine, under appropriate mandates and protocols, how access can be facilitated and respected.

The RHS has succeeded in creating awareness of privacy; producing ethical research; creating a capacity for data collection; advancing computer technologies among First Nations communities.

The right of First Nations communities to Own, Control, Access and Possess information about

[11] Regional Health Survey – 2002 (NAHO)

their peoples is fundamentally tied to self-determination and to the preservation and development of their culture. OCAP allows a community to make decisions regarding why, how and by whom information is collected, used and shared for research, evaluation and planning purposes.

First Nations (COO)[12]

The Chiefs of Ontario Organization (COO) is one of the primary organizations representing First Nations in Ontario. COO provided input into an Aboriginal Health Blueprint which was drafted for review by First Ministers in November 2005.

Ontario First Nations see the Health Blueprint as a Framework for actions to be taken by the federal, provincial and territorial governments over the next ten years, to restore and improve the health of First Nations peoples, and other Aboriginal peoples across Canada.

The Ontario Chiefs have stated that a First Nations specific stream must be established to ensure First Nations' Inherent Aboriginal and Treaty rights and our special relationship with the Crown are respected and clearly outlined, and that a distinct Ontario First Nations Blueprint is recognized at this time.

First Nations are seeking the establishment of a distinct yet interdependent or strategically linked First Nations Health System that supports First Nations Health Authorities. First Nations maintain that their laws, regulations and standards must be recognized by federal, provincial and territorial (FPT) governments. The engagement process reiterated the need for First Nations-specific, self-determined health services - i.e. those services designed, developed and delivered by and for First Nations peoples whether living on or away from reserves.

Chiefs in Ontario have identified other priorities, including:

- First Nations Health Authorities require a global and multi-year funding mechanism that would encompass not only health services, but related programs currently funded by Indian and Northern Affairs Canada (INAC). They require that resources to First Nations across the regions be allocated in proportion to population, noting that Ontario First Nations constitute close to 25 percent of the First Nations population in Canada.

- Funding agreements must also be established on a nation-to-nation basis and real and meaningful consultation and consent are required prior to any changes to programs, policy or legislation impacting on First Nations both on and away from the First Nation community.

- In terms of roles and responsibilities for First Nations health the Crown must honour its fiduciary obligations to First Nations including historical, constitutional and modern day obligations for First Nations health care.

- Canada and Ontario must respect and support the role of First Nations governments in relation to health, i.e. the broader inherent right of self-government that includes jurisdiction over health, citizenship and other core functions

- First Nations also support more coordination and linkages with provincial health services. However, new mechanisms

[12] COO has a full time Health Secretariat

for planning and implementation of health services in Ontario are presently being established through the Local Health Integration Networks (LHINs) without resolving the representation or the consultation issues within jurisdiction that involve nation to nation consultation – again, the duty to consult First Nations communities on health issues and needs in the overall context of the LHINs. First Nations authorities and governments require First Nations-specific structures and vehicles to plan and implement health services for First Nations peoples in Ontario.

- The poor health of First Nations people must be acknowledged by federal and provincial governments as an urgent priority in recognition of the urgent need for better service delivery, access and more action to address significantly poorer health status.

- A First Nations Primary Care Strategy must be developed immediately to improve timely access by First Nations people to doctors, nurse practitioners, specialists, dentists, traditional and alternative practitioners, etc.

- Medicine people, traditional healers and midwives must be acknowledged, recognized, supported and duly compensated as primary health care providers.

- Appropriate work space and resources must be made available to encourage them to practice in First Nations communities, urban Aboriginal health facilities and mainstream health care centres.

- Medical transportation framework policies must be revised with direct input from First Nations to reflect rising needs and costs and to ensure flexibility and reasonability. Terms such as "remoteness", northern access issues, urban challenges must be jointly defined and clarified by First Nations, other governments and service providers

- A major reform of the Non-Insured Health Benefits (NIHB) Program must occur to define core delivery principles, benefits and portability in terms of access, universality and OCAP principles. NIHB reform must establish strong community and regional linkages to national decision-making processes. Full First Nations consultation must be undertaken as a first step.

- Increased demands for community-based medical home care, end-of-life care and in-home long-term care for elders and people with disabilities must be addressed and properly resourced, and accurate data gathered about gaps in availability of appropriate Long Term Care facilities.

- New tools must be developed by and with First Nations for diabetes prevention and self-management, sexual health, HIV/AIDS prevention, chronic disease prevention, healthy lifestyles including smoking cessation and harm reduction, and health promotion.

- The challenge and social/family/health impacts of increased prescription and other drug dependency/abuse, solvent abuse, and related upsurge in violence must be addressed.

- More and earlier assessment of First Nation children's health must be available to identify and provide services for hearing, speech, autism, FAS/FAE, mobility and other needs.

- Standards of care and program/service delivery, and related performance indicators must be established and implemented.

Métis (MNO)[13]

As all three Aboriginal Peoples have different histories, experiences and related health outcomes, data based only on First Nations does not provide an adequate or appropriate measure of the health needs and status of Métis or Inuit. A great need exists to complete more research in order to appropriately determine the health status, well-being, and health needs of Métis. Unfortunately, there are several issues impacting the ability to provide Métis health information, namely:

Inaccurate Or Incomplete Data Sources - Uncertainty over identity and jurisdiction of Métis individuals and communities – i.e., who are the Métis, where do Métis people reside, and what level of government (federal, provincial or territorial) is responsible for delivering health services to this segment of the Canadian population of relevant or available data.

Inability To Extrapolate Or Access Data, Or Exclusion From Data Collection - Given the reality of inaccurate and incomplete data sources due to issues surrounding Métis identity and rights to services, it remains extremely difficult to measure the health of Métis populations based on scant data.

Limited Opportunity For Métis To Self-Identify As Métis - Métis health services are the responsibility of provincial and territorial governments, with few federal programs existing that include and/or outreach to Métis people or communities. Most provincial and territorial health programs and services offer the same services to Métis as for the overall, non-Aboriginal population.

The enumeration of all Aboriginal peoples is a contentious issue. While provincial Métis organizations have membership lists of Métis within their jurisdiction, the federal government, through Statistics Canada, is the only source of national enumeration figures of Métis.

There is a need for consistent, comprehensive and comparable data on Aboriginal peoples. the urgent need to "stabilize and expand" the current data infrastructure - the lack of overall health status data on Métis in Canada and the need for further research to ensure that Métis become more represented in health data analysis, interpretation and resource capacity.

A paradigm shift needs to occur that moves health systems from an illness based model to one that stresses population health, prevention, individual decision making and overall responsibility for health.

A holistic model which bases health services on the interconnected determinants of health such as social services, education, housing, economic development, the criminal justice system, etc.

Decisions concerning services and traditional medicine knowledge and practices should be determined by community needs and preferences.

Two over-riding conclusions from Improving the Health of Canadians directly pertain to Métis health issues and status:

There is a need for better data for surveillance and evaluation. Currently, there remains

[13] Metis Nation of Ontario – one of several Metis organizations in Ontario

inconsistent, non-comparable and non-comprehensive data on Aboriginal peoples in Canada, especially for Métis and Inuit. First Nation's data collected through various census and research cannot speak for Métis or Inuit health status, well-being or health indicators.

Action s required to address the determinants of health for Aboriginal peoples that reflect the holistic perspective of well-being.

Inuit Priorities[14]

- Health delivery: lack of doctors and sufficient other health staff in communities; lack of services/programs; waiting for services and test results; poor communication and explanations; lack of interpreters; lack of cultural knowledge/ insensitivity in health providers; transportation.

- Specific health issues: the addictive behaviours (drugs/alcohol/smoking/ gambling) and a need for specific information and counseling; mental health issues; nutrition and food quality/expense; a need for more health information, including information in Inuktitut; more counseling; homecare; information and knowledge.

- Personal/social issues: better communication; individual, family and community involvement and responsibility; family finances;

- Socio-economic issues that relate to health: poverty and lack of employment; lack of education; overcrowded housing;

- Culture loss/culture change: loss of Inuit language, values, skills, food. Labrador especially noted political and management issues as well: expectations; financial issues; poor management; lack of community control and input to government; Non-Insured Health Benefits information; and lack of training.

Common concerns related to the health and wellness of infants, children and youth were:
poor nutrition; overcrowded housing; parental neglect, need for parenting skills and need for family involvement; early childhood development (pre- and post-natal classes for mothers and babies and daycares); loss of language, culture and contact with Elders; Fetal Alcohol syndrome/Fetal Alcohol Effects (FAS/FAE);
tobacco/drug/alcohol use and information;
abuse (physical, emotional, sexual) teenage pregnancy and lack of information/knowledge related to high-risk sexual behaviour (sexually transmitted diseases, HIV); lack of services and activities for youth, including opportunities to express feelings youth suicide lack of self-esteem life skills, coping skills (anger, communication) in youth; school dropout rates; and, need for positive role models

Aboriginal Peoples' Health: The Deeper Issue

As previously stated in the overview, new health promotion tools must be developed by, for and with Aboriginal peoples to address some of the larger issues indicative of poor health for Aboriginal peoples overall. Such larger issues as diabetes prevention and management, sexual health, HIV/AIDS prevention, chronic disease prevention, smoking cessation and harm reduction, FAS/FAE, abuse (physical, sexual,

[14] National Inuit priorities identified by the Ajunnginiq (Inuit) Centre at NAHO

emotional, mental), including alcohol abuse, family violence and youth suicide are some of the more pervasive issues affecting Aboriginal peoples' health as a whole.

Yet in many circles, these issues are considered to be not only negative indicators of poor health, but also negative indicators of a deeper underlying problem that affects Aboriginal peoples worldwide. This deeper underlying issue has been referred to in much of the contemporary literature by names such as lateral violence, historic trauma transmission, post-traumatic stress syndrome and in this report, it is referred to as an "Ethnostress" that lies at the root of many of the psycho-social ills and physical problems affecting Aboriginal peoples of which poor health is but one.

For the purpose of definition, Ethnostress comes from two words; "ethnicity" which refers to the roots of our Aboriginal identity and "stress" which pertains to the impact that colonization and historical oppression has had on the psychological and social development of the Aboriginal person, family, community and nation. In short, living within Aboriginal communities is a very stressful experience. But, to simply state this as such does not do the concept justice.

The term, ethnostress, refers most specifically to the disruption and loss of a positive Aboriginal identity and the impact that this disruption of identity has had on nations of Aboriginal peoples and their cultures. Today, many health, education and social service professionals working within Aboriginal communities today believe that the disruption of a positive and healthy Aboriginal identity is the deeper underlying issue responsible for creating many of the negative indicators of poor health mentioned previously.

According to the Royal Commission on Aboriginal Peoples' Report (RCAP) of 1996, the disruption of an Aboriginal way of life, that included the mechanisms for fostering a strong Aboriginal identity, was brought about most notably by the impact of the residential school system as one of the chief colonizing devices. "Put simply, the residential school system was an attempt by successive governments to determine the fate of Aboriginal people in Canada by appropriating and reshaping their future in the form of thousands of children who were removed from their homes and communities and placed in the care of a stranger (p. 335)." The Canadian policy of assimilation and civilization "required a concerted attack on the ontology (their view of reality), on the basic cultural patterning of the children and on their world view. They (the Aboriginal people) had to be taught to see and understand the world as a European place within which only European values and beliefs had meaning; thus the wisdom of their cultures would seem to them only savage superstition. A wedge had to be driven not only physically between parent and child, but also culturally and spiritually (p. 341)."

Over the years, Aboriginal human service professionals have observed the impact that this early history had on the identity of Aboriginal people. We know that our identity is our sense of self and a strong sense of self is shaped in the early years of our life when we can be loved as a precious child who has a purpose, who is acceptable, who belongs and has a place in the world; a child whose very existence is beneficial and who has a sense of safety and security because he/she also lives in a world with sufficient food, healthy water and a warm shelter. These are the basic needs required by all human beings and they act as the foundation for a strong sense of self that is further supported

and enhanced if the child receives positive affirmation of his/her sex and identity as an Aboriginal person. Unfortunately, the history of our contact with non-Aboriginal peoples has not been a positive one and the conflict between cultures continually works to disrupt the unique Aboriginal cultural beliefs and social practices that would have supported the development of a strong and joyful Aboriginal identity.

Ethnostress results when oppressive conditions are forced upon a people in their own environment. From this negative experience, a negative self-image begins to form and is then passed down to future generations. Having internalized the negative experiences and negative imagery of what it means to be an Aboriginal person, many Aboriginal people have learned to "hate" themselves and to harbor feelings of shame and resentment. Once this negative imagery and the associated feelings are internalized within the emotional and mental psyche of a person, they then work to establish a negative self-concept that reinforces feelings of low self-esteem.

At its highest level, ethnostress is characterized by strong feelings of powerlessness and hopelessness. Often, these are the very feelings that work to disrupt our ability to achieve even our most basic needs. These are the feelings experienced by those community members who contemplate and take the chance of attempting suicide. But most importantly, we now understand that the negative feelings (anger, fear, hurt, loneliness, shame) and the rigid and distressful behaviour patterns associated with the Ethnostress phenomenon is what is responsible for the development of many of the health issues, stress-related disorders and chronic diseases that affect Aboriginal peoples today.

If we are to rid Aboriginal communities of the abusive use of alcohol and drugs and other addictions such as smoking, gambling, compulsive and harmful sexual behaviours, the chronic diseases fueled by various stress-related disorders and incurable diseases such diabetes and HIV/AIDS, then we must direct our attention to the development of promotional tools and resources that can help Aboriginal people to heal themselves, their families and communities. There is a need for promotional materials that will educate both Aboriginal and non-Aboriginal people alike on the existence and importance of the Ethnostress phenomenon and its relationship to health. Many health workers in Aboriginal communities are often faced with the task of assisting and helping people who are filled with painful memories and emotional traumas stemming from their unmet needs. Not all of the behaviour patterns developed to meet those unmet needs will be healthy and these unhealthy behaviours that complicates our ability to make good choices for ourselves; the kind of healthy lifestyle choices that would promote health within Aboriginal communities.

Aboriginal Health Promotion Resources

Currently, the health promotion resources and services that are tailored for Aboriginal people are limited. They are delivered on an ad hoc basis and often in isolation from the Aboriginal population. While there is a great need for health promotion within the Ontario Aboriginal population, progress in meeting this need has been slow.

Often, the development and delivery of health promotion resources is impacted by external forces and funding priorities, by overwhelming

internal workloads that that influence community priorities and by a general limitation on the types and kinds of resources available to the Aboriginal population. There is a general need for health promotion resources to be developed within an atmosphere that recognizes the need for cultural awareness and a degree of cultural competence that would support the building of relationships between Aboriginal health providers and provincial/federal agencies.

To understand the complexities in addressing not only the health promotion needs of Aboriginal people but also their more general health needs, it is necessary to have an understanding of the ethnostress phenomenon that impacts the psycho-social development of Aboriginal people. Equally, it is important to be aware of the more prevalent issues that characterize the health status of Aboriginal people in general and that includes an awareness of the social-political linkages that exist within the Aboriginal population. Any development and delivery of heath promotion resources for the Ontario Aboriginal population will require an understanding of these topic areas due to their influence and impact.

In this report, we have attempted to provide an overview of the topic areas mentioned. However, for a deeper appreciation, you are encouraged to read volume three of the Report of the Royal Commission on Aboriginal Peoples and the First Nations Regional Health Survey of which a CD copy of the latter report has been provided as an addendum to this report. Unfortunately, no similar data is readily available on Métis and Inuit health in Ontario.

In the next two sections to follow, we will briefly discuss cultural competence and cultural awareness as it relates to "health promotion services that are tailored for Aboriginal people and how they are delivered and by whom". We will also provide an overview of the linkages and how this may affect the work of the Ontario Health Promotion Resource System (OHPRS).

It is important to highlight the progressive and culturally acceptable approach OHPRS is currently taking to understand the Aboriginal population as a first step in identifying a system level plan. This initial awareness and understanding will undoubtedly help to increase the OPC capacity to effectively serve the Aboriginal population in a way that is consistent with their mandate and systems. This approach follows recommendation 3.3.24 a., b., and c. of the Report of the Royal Commission on Aboriginal Peoples that states:

> "Non-Aboriginal service agencies and institutions involved in the delivery of health or social services to Aboriginal peoples, undertake a systematic examination to determine how they can encourage and support development of Aboriginal health and social service systems, and improve the appropriateness and effectiveness of mainstream services to Aboriginal peoples; (and) engage representatives of Aboriginal communities and organizations in conducting such an examination."

So presently, who is providing promotional resources to the Aboriginal population? Where are they presently obtaining their promotional resources? What are the priorities?

Before we can answer these questions, we need to first look at the general health issues affecting Aboriginal peoples.

General Health Statistics Relevant to the Aboriginal Population

A cursory look at the health statistics of Aboriginal people, as highlighted in the First Nations Regional Health Survey, reveals the most common health conditions as being: heart disease, hypertension, arthritis/rheumatism, asthma, cancer, injury, diabetes and parental wellness. Several summary statements are as follows:

- First Nations adults have a higher rate of hypertension than Canadian adults.
- First Nations boys (children) are more severely affected by asthma than girls.
- Approximately one in ten of First Nations children and one of five First Nations youth suffer from chronic ear infections.
- The most common age of first pregnancy or fathering a child was 16 years of age.
- Life expectancy at birth is about seven to eight years less for registered Indians (First Nations) than for Canadians generally.

Diabetes:

- Diabetes among First Nations people is often linked with being overweight and obese.
- Prevalence of heart disease and hypertension among First Nations adults with diabetes is four times higher than that found in First Nations adults without diabetes.
- The average age of diagnosis of diabetes in First Nations youth is 11 years.

Injury:

- First Nations adults report injuries at a rate of almost three times the Canadian average.
- Injury is ***the*** leading cause of death in First Nation communities.

Impact of Residential Schools:

- A majority of First Nations residential school attendees witnessed the abuse of others or experienced it themselves.
- First Nations adults believe their parents' attendance at residential school negatively affected the parenting they received.
- Almost 60% of First Nations children have one or more grandparents who attended residential schools.

Tobacco:

- For all age groups and genders, smoking is approximately twice that found in the Canadian population.
- Just over half of the First Nations pregnant women were smokers at the time of the survey.

Mental Health:

- First Nations people felt strongly that their community was not progressing in relation to reducing alcohol and drug abuse.

Dental:

- Baby Bottle Tooth Decay is a serious problem with First Nations children.
- Although First Nations children have a high level of dental care, this has not reduced the need for treatment services such as fillings.

Alcohol and Drug:

- Most First Nations adults abstain from drinking alcohol in comparison with the general Canadian population.
- Most First Nations adults who do drink alcohol are moderate drinkers.
- The proportion of heavy drinkers in First Nations adults is higher than the general Canadian population.

Nutrition:

- Over half of First Nations children and less than half of First Nations youth are overweight or obese.
- The proportion of adults who are usually eating a nutritious and balanced diet increases with age, education and personal income.
- A large proportion of First Nations adults are considered overweight and obese.
- First Nations youth and children make up one third of the First Nation population. Therefore the high rates of overweight and obese children signals serious future chronic health problems.

1. Promotional Material Access

Aboriginal people are considered the responsibility of the federal government. Therefore access and development of many services and resources that would address the specific needs of the Aboriginal population are limited. In a First Nations Environmental Scan completed in 2006, it was found that there was minimal contact with federal health promotional professionals. This minimal contact is compounded by an overwhelming demand by the Aboriginal population to meet their basic needs with the limited resources available. In this context, the development of promotional material is at best inadequate.

When we ask Aboriginal people, where they access their promotional material, they respond as follows: from Indian Northern Affairs Canada; from researching and accessing material off the Internet that they may or may not adapt; and simply from finding resources wherever they can. From the First Nations Public Health Environmental Scan, one individual is quoted as saying, "It's the little things like the health materials and all the tools that you need....and [it's the] resource material that we don't have. We are trying to access that information through the provincial public health units and its all dependent upon who you are connecting with at that level [as to] whether the support may be there."

There are examples where Aboriginal services and/or agencies have written proposals and accessed resources as a way of developing a specific cache of resources that they use until the supply has been exhausted. However, because the development of this type of resource base was a one-time initiative, replenishing the needed resources is not possible. The on-going and continual replenishment of promotional resources is simply not a part of their core budgets.

In other instances, Aboriginal populations in Ontario access promotional material that may or may not be Aboriginal-specific. These include access to the:

- Southern Ontario Aboriginal Diabetes Initiative
- Northern Ontario Diabetes Network
- Aboriginal Tobacco Strategy
- First Nations Inuit Health Branch
- Ministry of Health

An understanding of this reality brings us to the question of whether or not there is an opportunity for OHPRS to support and increase its capacity to effectively serve Aboriginal populations given the system's resources and capacity. The answer to this question is yes. A great opportunity exists for OHPRS to increase its capacity to effectively serve the Ontario Aboriginal population.

2. Can this process be improved?

Most definitely is the short answer. However, if you want to promote health in Aboriginal populations, the current model of health that focuses on the treatment of disease must be challenged. A strategy promoting Aboriginal notions of wholistic health would work to offset the current disease-based approach.

A willingness to adapt what is considered to be mainstream promotional material by better matching these materials to an Aboriginal style of learning that would appeal to Aboriginal lifestyles is another option. In this instance, providing resources with large amounts of written material is not always the best approach. Resource material with pictures accompanied by key messages that match the identified statistics specific to the Aboriginal population would be more effective. Such resource materials could contain contact information (i.e. website links) and either toll-free or local telephone numbers that would encourage Aboriginal people to call for additional information. When undertaking the development of any health promotional materials, it will be important to take into consideration the oral nature and style of communication and the oral transmission of information that is a reality of Aboriginal life.

A prime example of an external agency that provides effective promotional material is the Aboriginal Tobacco Strategy found within Cancer Care Ontario. The Aboriginal Tobacco Strategy and the Aboriginal Cancer Care Unit (ACCU) has developed some promotional material that focuses on Aboriginal youth as a specific target group. Their strategy is to prevent the commercial use of tobacco by increasing the awareness of Aboriginal youth.

Basing their approach on the development of relationships with their specific target population, they begin by initially leading the creative process. Once material has been conceptualized, they either market test the draft material or develop a working group of stakeholders to help them to further refine the development of their promotional material. This agency also develops Aboriginal-specific promotional material such as the ACCU Aboriginal newsletter where a discussion of Aboriginal-specific issues and relevant Aboriginal community approaches to tobacco use may be found. The agency also develops material based on Aboriginal notions of wholistic health that focus on the promotion of healthy lifestyles while providing the relevant Aboriginal-specific statistical information.

3. Appropriate Process in Aboriginal Communities

A few processes for developing and tailoring materials are being utilized at present.

First, resources are developed based on a set of goals and objectives designed to address a specific issue. In this case, development occurs based on an external understanding of Aboriginal culture. A quick look at this approach would indicate that it would be the same approach taken by Aboriginal people. However, the difference may be found in the philosophical approach taken and in the type of resource that is actually produced.

For example, the prevention of smoking and the need to decrease the incidence of cancer is a common goal for health service providers, government and the Aboriginal population alike.

However, there is a difference in how this goal may be accomplished.

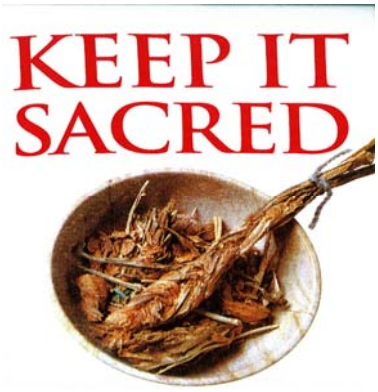
As noted in the Report of the Royal Commission on Aboriginal Peoples and the First Nations Regional Health Survey, there is a tendency for the more "powerful" party to try to force its own way of doing things on another party by assuming that their way is clearly the "normal" or "better" approach to getting things done.

However, in working with an Aboriginal partner, it is imperative for all health resource partners to stay focused and to not lose sight of the key questions such as: What goal(s) are to be achieved? Who is the target group? What works most effectively with that target group? What are the cultural implications relevant to the worldview that one is trying to impact? With these questions in mind, our approach to the goal(s) may differ, and this difference can have a huge impact on the final product that is developed.

We provide an example. Consider below, the development of a t-shirt to promote smoking cessation, or the use of commercial tobacco by Aboriginal people. One message focuses on a disease-based approach to smoking that is in keeping with the specific goals of the developer. The second message is based on promoting Aboriginal notions of health that focus on wholistic health and pride in one's cultural heritage. Agreement on the overall goal is achieved – the prevention of smoking – yet the end result in the two approaches vary significantly. The following pictures depicting the promotional products created by these two approaches appear below:

Picture 1: A provincial Ministry t-shirt

Picture 2: Aboriginal Tobacco Strategy t-shirt

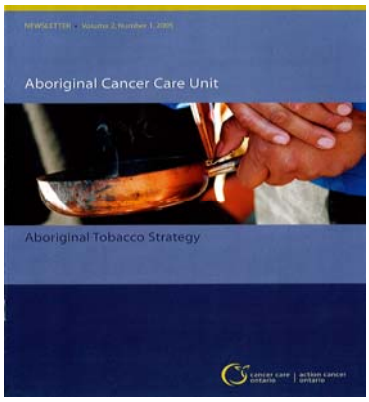


The question then is: Towards which t-shirt do you think the Aboriginal population will gravitate?

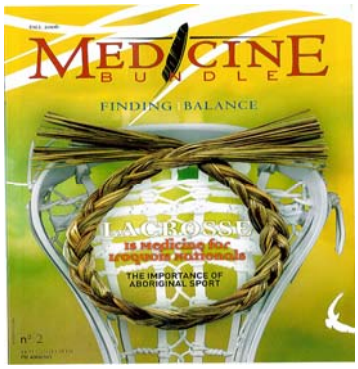
Second, a collaborative approach to resource material development occurs when the stakeholders are partners and the stakeholders are leading the development of the promotional material.

In this example, the goal is to develop an Aboriginal newsletter to increase awareness of Aboriginal healthy lifestyles and well-being. Here, Aboriginal stakeholders are brought together either to lead or to help guide the development of the newsletter. The end results are as follows:

Picture 1: An external agency newsletter targeted for Aboriginal peoples health with development led by culturally competent people.



Picture 2: An Aboriginal-led initiative in the promotion of Native health.



A third approach would be to adapt any existing material originally developed for mainstream society and services. Generally, this is what many Aboriginal health service delivery agents do. It is an approach that can be accomplished through using any one of the above-mentioned processes. However, the question remains, which process do you think would better capture the attention of an Aboriginal target audience?

How Does One Effectively Build A Supportive Aboriginal Network?

A key element in building a supportive network with the Aboriginal population requires health promotion services to not just have, but be able to provide accurate information. Aboriginal people have suffered with and continue to suffer from the damaging effects of prejudicial bias and racism. Since the news media in general makes little effort to provide accurate information on Aboriginal issues, agencies and/or services that take the time to research, collect and verify their information with input from the Aboriginal population are respected. Other key elements to building an effective and supportive Aboriginal network lies in an agency's ability to build trust through the establishment of personal relationships between agency representatives. Being able to bridge the cultural gap that exists between Aboriginal and non-Aboriginal people by being aware of the cultural differences and by becoming culturally competent is another supportive measure that can be taken.

Education and cultural accommodation are key processes in establishing and building a supportive Aboriginal Network. In part, the bridge-building process begins with an understanding of where Aboriginal populations are located with some thought being given as to how these populations can be represented within the membership of the various OHPRS partner agencies. An Aboriginal presence likely exists in every town, city and rural area across Ontario with as many as 60% of Ontario's Aboriginal population reported to be living in urban settings. In addition, there are one hundred and thirty-four (134) First Nations, twenty-eight (28) Aboriginal Friendship Centers situated in urban settings and various types of Métis settlements located throughout Ontario. An out-reach strategy to develop working relationships and to establish a network with any of these Aboriginal entities would be ideal.

Creating opportunities for meaningful interaction is an inherent part of the

relationship-building process. Building a meaningful interaction means developing a relationship that is both personal as well as professional. Thus, a meaningful interaction can be as simple as making an on-site visit to introduce the agency and to express agency interest. Yet, it is important to understand that in the Aboriginal world, a meaningful interaction often goes beyond the initial introduction of self and the expression of an agency interest to help. For Aboriginal people, a meaningful interaction often entails an on-going dialogue of how we can help each other through the active listening and the sharing of ideas proposed over the course of a number of meetings that may take place in a variety of meeting venues. The Mayor of Kamloops, Clifford Branchflower explains:

> "It is a great deal easier to reject the ideas and aspirations of people (agencies) with whom we have never shaken hands, with whom we have never laughed together over a joke, or with whom we have never sat down to a shared meal."

At this point, it can be stated that the OHPRS has access to numerous resources that could benefit Ontario's Aboriginal population either with or without adaptation. There appears to be an opportunity for the OHPRS member agencies to develop Aboriginal-specific resources and to partner with Aboriginal health providers to ensure cultural competence in the development of health promotion materials. Meaningful interaction with Aboriginal service providers could include extending invitations for them to form either a focus group or a working group. These groups could either work on or act as an advisory committee for the purpose of reviewing resources and for identifying local and regional target groups and health priorities. Where gaps have been identified, a joint strategy for the development and/or adaptation of Aboriginal promotional resources within the current fiscal realities could also be developed.

Another example of a meaningful interaction would be to invite Aboriginal people to become members of either an overall OHPRS conference or an agency-specific conference committee. Another approach would be to encourage OHPRS agencies to develop an Aboriginal working group as an advisory component of a conference committee that would like to ensure Aboriginal representation on their conference program or who might also consider planning and hosting an Aboriginal-specific conference.

The important thing to understand is that meaningful interaction is a fluid process. It is not a one-time event or a static process. Not enough can be said about the importance of creating on-going opportunities for both member and public education that can occur either in the existing forums or in hosting a session on Aboriginal health. Inviting George Erasmus to speak as the former Chair of the Royal Commission on Aboriginal Peoples and/or inviting the National First Nations Regional Health Survey Coordinator to make a presentation on their respective reports and key health findings is another strategy. Member OHPRS agencies that are willing to engage in discussions on the concepts of "cultural awareness" versus "cultural competence" with various Aboriginal representatives would be indicative of a proactive stance. Additionally, representatives of the OHPRS could initiate a request to meet with the Health Coordination Unit of the Chiefs of Ontario. Through this meeting, OHPRS would be able to introduce itself and at the same time, request the formal support and participation of the Chiefs of Ontario in a discussion of how OHPRS can

support Aboriginal people within the current OHPRS mandate and its available resources for health promotion. It is through these types of activities that OHPRS can demonstrate its genuine interest and desire to educate its member agencies and to build meaningful relationships with Aboriginal peoples.

In closing this section, we provide one ***"exemplary example"*** of a supportive Aboriginal network that is in existence today. This is a network that was built by Cancer Care Ontario. Their story is as follows. A number of years ago, Cancer Care Ontario identified the increasing rates of cancer amongst Aboriginal peoples. Simply put, Cancer Care Ontario had a desire to extend their experience, expertise and services to the Aboriginal population. Today, Cancer Care Ontario has a very strong presence within the Aboriginal population. They provide service, develop strategies, provide Aboriginal-specific resources and are accepted as a partner agency dedicated to improving "the appropriateness and effectiveness of mainstream services to Aboriginal peoples" in the cancer-specific target area. How did they do this? They undertook a systematic examination to determine how they could encourage and support the development of Aboriginal health specifically in the area of cancer. What steps did they take? First, they educated themselves on Aboriginal-specific linkages and political structure. Then, they invited members representing key Aboriginal stakeholders to a "think tank" session that would serve as an example and expression of their desire for a meaningful interaction. Cancer Care Ontario did not assume that they knew best. They did not move ahead to develop and impose their approaches of cancer care onto the Aboriginal population. They expressed their interest in helping and explained how they felt they could support Aboriginal health. They asked if cancer care was an area of interest to them as Aboriginal stakeholders and then, they asked them for their vision of how Cancer Care Ontario could be supportive in addressing Aboriginal cancer. As a result of these meetings, relationships developed, people laughed together, shared meals together and integrated their visions. Yes, there were intense moments of frustration as people struggled to accommodate the various aspects of Cancer Care Ontario's environmental culture with the Aboriginal culture. However, those early and sometimes difficult relations are what formed the backbone of the enhanced relationship that exists today.

Today, Cancer Care Ontario has an Aboriginal Cancer Care Unit as well as an Aboriginal Tobacco Strategy Unit that is made up of approximately seven personnel; four of which are of Aboriginal ancestry. Directing the Aboriginal Cancer Care Unit is a Joint Ontario Aboriginal Cancer Committee composed of representatives from the four First Nation political bodies, the Independent First Nations, the Métis Nation and Cancer Care Ontario. Throughout the joint committee development process, agency representatives addressed the issue of cultural competence, albeit innocently, but effectively.

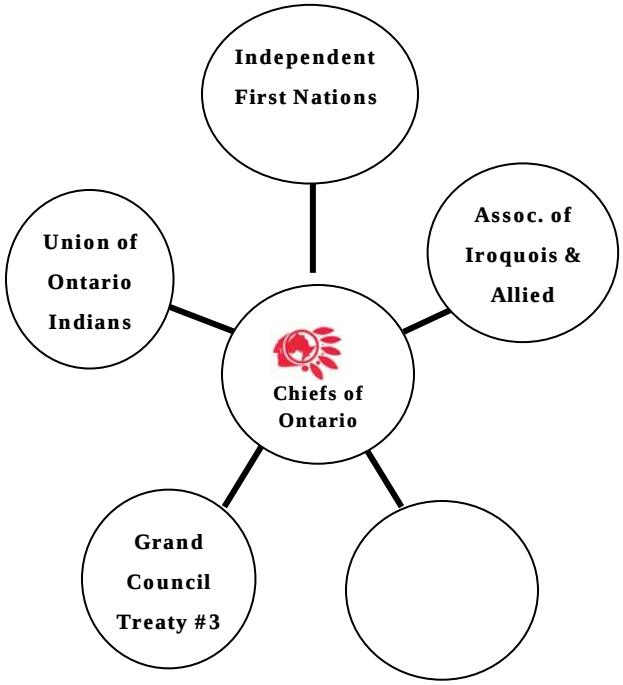
1. Linkages

In Ontario, there are four political territorial organizations and a technical body responsible for coordinating the Independent First Nations (IFN). Each of the four political territorial organizations (PTO's) represents a portion of the 134 First Nations present within the province of Ontario. Within each of these four organizations is a health director who is responsible for regional and national policy development. Also,

within Ontario, there is a regional coordinating body known as the Chiefs of Ontario and this body holds annual conferences for the purpose of bringing together all 134 First Nations to discuss community issues and to develop regional strategies and initiatives. The Chiefs of Ontario coordinates the Health Coordination Unit that is made up of the four PTO and IFN health directors. The Chiefs of Ontario Health Coordination Unit is the body that guides the technical development of health policy for the Ontario First Nations. As a complement to this political representation, there are 28 friendship centers that provide services to Aboriginal people living in urban settings. Political representation for these urban friendship centers is facilitated through a regional coordinating body known as the Ontario Federation of Indian Friendship Centers.

Also within Ontario, there is a Métis Nation of Ontario regional office in Toronto as well as a national office of the Métis Nation of Ontario that coordinates and represents the various Métis settlements distributed throughout Ontario. The Inuit population is limited within Ontario and can be primarily found as a cluster population in Ottawa.

A pictorial review of the First Nation political structure appears as follows:



Contact Information for Further Information

National Aboriginal Health Organization (NAHO)
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Ottawa, ON K1P 5Z9
613- 237-9462
Fax 613-237-1810
naho@naho.ca

Chiefs of Ontario
111 Peter Street, Suite 804
Toronto, Ontario
M5V 2H1
www.chiefs-of-ontario.org

Métis Nation of Ontario
500 Old St. Patrick Street, Unit 3
Ottawa, Ontario
K1N 9G4
613-798-1488
Fax (613) 722-4225
www.metisnation.org

Regional Health Survey
Assembly of First Nations
Health and Social
473 Albert St. 8th Floor
Ottawa, ON K1R 5B4
613-241-6789
www.naho.ca/firstnations/english/regional_health.php

Other websites of Interest:

Assembly of First Nations
www.afn.ca

Report of the Royal Commission on Aboriginal Peoples
www.ainc-inac.gc.ca/ch/rcap/sg/sgmm_e.html

Association of Iroquois and Allied Indians
www.aiai.on.ca

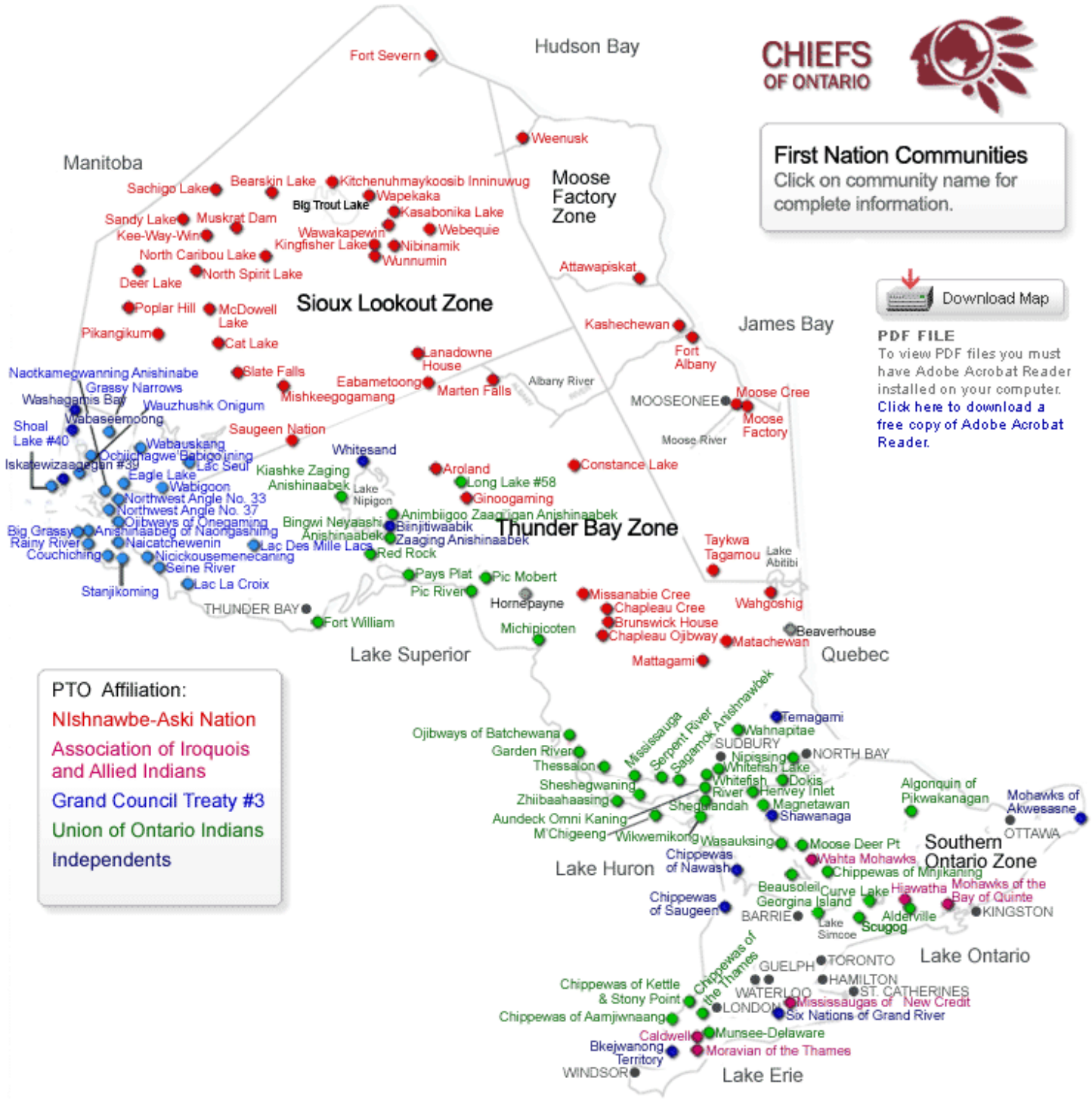
First Nations of Treaty #3
www.treaty3.ca

Nishnawbe Aski Nation
www.nan.on.ca

Union of Ontario Indians
www.anishinabek.ca

Ontario Federation of Indian Friendship Centers
www.ofifc.org

APPENDIX A: First Nation Communities in Ontario



Source: This map can be accessed at http://www.chiefs-of-ontario.org/profiles/map.html.

APPENDIX B: Friendship Centers in Canada